State of California

Department of Health Care Services

The Coordinated Care Initiative's Commitment to Quality: *Evaluation and Quality Monitoring Strategy*

To ensure beneficiaries receive high quality care under California's Coordinated Care Initiative (CCI), a rigorous evaluation and quality-monitoring program will be implemented. California will pursue a multi-faceted approach to measuring and evaluating the demonstration's progress toward integrating medical, long-term services and supports and behavioral health care for people with both Medicare and Medi-Cal (Medicaid). The components of California's quality monitoring and evaluation strategy include:

1) State participation in a CMS evaluation of the Medicare-Medicaid demonstration
2) State-specific evaluation
3) Ongoing process for monitoring care quality and health plan performance

This fact sheet summarizes the major components of the evaluation and quality monitoring process for California's demonstration.

Coordinated Care Initiative Core Aims

California's monitoring and evaluation strategy will focus on the Coordinated Care Initiative's following core aims:

1. Streamlining and simplifying service delivery
2. Reducing fragmentation of care
3. Improving beneficiaries' quality of life
4. Improving beneficiaries' satisfaction with service delivery
5. Improving health outcomes
6. Slowing the growth of health care expenditures

CMS Evaluation for Cal MediConnect

CMS is funding and managing an evaluation of each state's demonstration, including California's. CMS has contracted with an external independent evaluator, RTI International, to measure, monitor, and evaluate the overall impact of the demonstrations, including impacts on Medicare and Medicaid expenditures and service utilization. In addition, the evaluation will seek to understand how the initiatives operate, how they transform and evolve over time, and what impact they have on beneficiaries' perspectives and experiences.

The key issues targeted by the evaluation will include (but not be limited to):

- Beneficiary health status and outcomes
- Quality of care provided across care settings and delivery models
- Beneficiary access to care across care settings and payers
- Beneficiary satisfaction and experience

- Administrative and systems changes and efficiencies
- Overall costs and savings for Medicare and Medicaid

The CMS evaluation methods will use qualitative and quantitative approaches, including the following:

- Conducting site visits; qualitative analysis of program data; focus group and key informant interviews;
- Tracking changes in quality, utilization, and cost measures;
- Evaluating the demonstration impact on quality, utilization, and cost measures; and
- Calculating savings attributable to the demonstration.

State Quality Monitoring and Oversight

In addition to participating in the CMS evaluation of the Medicare-Medicaid demonstrations, California is implementing its own approach to measuring and monitoring quality of care and services provided. California's approach is being developed by DHCS with significant stakeholder input. DHCS is working on evaluation design and implementation, as well as program interventions, such as rapid-cycle quality improvement program that will enable DHCS to monitor and collect data to inform program adjustments that ensure high quality care delivery.. Any state evaluation process will align with the CMS evaluation, and as much as possible, the state will use the CMS evaluation metrics to allow for an "apples-to-apples" comparison.

Along with participating in the CMS evaluation, DCHS will oversee a rigorous quality monitoring process. The State, in collaboration with CMS, will establish a process for ongoing plan oversight and monitoring that will include reviewing and addressing critical incidents and events.

Specifically, DHCS, in collaboration with other departments in California's Health and Human Services Agency, will monitor the health plans' performance through the following activities:

1. Develop performance measures to provide quality indicators for beneficiaries enrolled in a managed care health plan.
2. Develop quality assurance indicators for long-term services and supports in consultation with stakeholder groups.
3. Provide an annual report to the Legislature describing the degree to which participating health plans have fulfilled the quality requirements in their contracts.
4. Provide an annual report to the Legislature jointly with the Department of Managed Health Care that summarizes independent audits and financial examinations of the health plans.
5. Provide to the Legislature a quarterly summary of LTSS utilization.